DRAFT

CONSUMER DISCOUNT HEALTH CARE SERVICE PROGRAM REGULATIONS

1300.49. Consumer Discount Health Care Service Programs

(a) Definitions:

(1) A "consumer discount health care service program" ("discount program") is a program offered by a licensed health care service plan or specialized health care service plan to enrollees and which:

(A) provides members access to otherwise excluded health care services, as specified in subdivision (p), and related products at rates that are discounted from the usual and customary rates charged by health care providers; but

(B) requires that the members pay the providers directly for those discounted services and products.

(2) "Member" means any enrollee participating in a discount program offered by the enrollee's plan.

(3) "Plan" means any health care service plan or any specialized health care service plan.

(4) "Provider" means any person or entity that provides health care services or products to members of the discount program.

(5) "Usual and customary rate" ("UCR") means the fee for a health care service or product that a health care provider participating in the discount program routinely receives in the normal course of business from a nonmember private paying patient without insurance or other third party reimbursement. Routinely waived co-payments may not be included in the "usual and customary rate."

(b) A discount program shall not be deemed to be a plan as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), and is, therefore, not subject to licensure. Nor will a discount program be deemed to be a plan subject to licensure solely because the discount program contracts with a plan to provide discount services or products.

(c) (1) Before offering a discount program a plan must have filed a notice of material modification with the Department of Managed Health Care. The Department must have issued an order of approval of the material modification prior to any services being provided under the discount program. Only those portions of the discount program covered by the Department's order of approval of the material modification may lawfully be implemented by the plan.

(2) If the plan is already offering a discount program, either directly or indirectly, that plan must file a notice of material modification with the Department of Managed

Health Care within 60 calendar days of the effective date of these regulations. The plan may lawfully continue to offer only those portions of the discount program which are covered by the Department's order of approval of the material modification. Any portion of the discount program for which the plan has not submitted a notice of material modification within 60 calendar days of the effective date of these regulations must be terminated on the 61st calendar day following the effective date of these regulations. Any portion of the discount program for which the plan does submit a notice of material modification, but which is not covered by the Department's order of approval, must be terminated within 60 calendar days following receipt of the Department's order.

(d) A plan may offer a discount program either "directly" (through a contract between the plan and members of the discount program) or "indirectly" (by contract with a separate entity) only to its enrollees.

(e) Any plan offering a discount program, either directly or indirectly, must require that each and every provider offering discounted health care services or products under the discount program enter into a written agreement which:

(1) expressly sets forth the services and products to be provided at a discount, the amount of the discount, and that provider's usual and customary rates to which the discount applies;

(2) expressly prohibits the provider from charging members more than the discounted charges;

(3) expressly prohibits the provider from preventing members of the discount program from participating in sales and other promotions offered by the provider to the general public which offer fees or costs that are lower than the discounted fees or costs set forth in the agreement;

(4) shall require each provider of discounted services or products to maintain professional liability insurance of the type and in the amount that is in accordance with generally recognized industry standards;

(5) shall prohibit the provider from paying any fee or other compensation to the discount program for entering into the agreement; and

(6) shall require that each provider verify that any and all licenses required by local, state, or federal agencies, boards, associations, committees, etc., have been obtained, and are maintained in an active status throughout the entire time that the provider offers discounted health care services or products under the discount program.

(f) If the plan offers the discount program directly, an agreement including the provisions specified in subsection (e) shall be entered between the plan and each provider of discounted services and products. If the plan offers the discount program indirectly, the plan shall ensure that the agreement including the above provisions has been entered into between the separate entity and each provider of discounted services and products, and the plan shall maintain a copy of each such signed agreement. The plan shall maintain these agreements in a readily accessible manner, and shall provide any or all of them upon the request of the Department. At the request of the Department, the plan shall demonstrate that the discount is applied to the provider's true usual and customary rate.

(g) (1) If the plan offers the discount program directly, through a contract between the plan and members of the discount program, the discount program must have a name that is distinct from other products and benefit plan types offered by the plan.

(2) If the plan offers the discount program indirectly, through a contract with a separate entity, the plan must include in the contract with that separate entity a prohibition against using the same name, or a name similar to, the name under which the plan is either licensed to do business, or doing business.

(h) Any plan offering a discount program must provide disclosure materials containing all of the following information:

(1) A general description of all services and products offered through the discount program, the types of providers available, how the providers' discounts are calculated and the range of discounts available, and a statement that the program does not guarantee the quality of the services or products offered by individual providers beyond confirming the existence and good standing of the professional credentials of the provider;

(2) A toll-free number and, if available, a website address, where individuals may obtain lists of providers and information regarding the fees or prices charged by each provider participating in the program, and additional information so as to afford full and fair disclosure of the discount program;

(3) A statement, in at least 12-point boldface type, that a discount program is NOT insurance (the word NOT must be capitalized) and that the member must pay the entire discounted charge;

(4) The right of any person enrolled in a discount program to cancel the discount membership at any time, without affecting in any way that person's entitlement to health benefits covered by the health plan outside the discount program;

(5) A statement, in at least 12-point boldface type, that a member may rescind his or her membership within 30 calendar days of joining the discount program, without needing to give a reason, and will be entitled to a complete refund of all money paid to the plan or to the independent contracted entity to become and/or remain a member of the discount program, but that money paid, or bills incurred, for services or benefits received under the discount program are not subject to rescission under this regulation; and,

(6) A statement, in at least 12-point boldface type, disclosing the amount of any ownership interest in the discount program held by the plan, or by any medical group or independent physician association contracted with the plan;

(7) A statement, in at least 12-point boldface type, that services offered under the discount program may not duplicate services actually offered, or required to be offered, under the Evidence of Coverage for the plan contract then in effect for that plan enrollee;

(8) A statement that the member may file a grievance under the plan's grievance procedure, and that all grievances except quality of care grievances will be processed under the plan's grievance procedure; but that a grievance about quality of care will not be processed under that grievance procedure, but the member will be informed of the name, telephone, and address of the licensing agency to which the member should direct the quality-of-care complaint. The statement must explicitly state that a grievance about a provider not agreeing to provide a service or product offered under the discount program will be processed under the plan's grievance procedure.

(i) The plan shall file with the Department all advertising, solicitation, and disclosure materials used by any discount program offered by the plan, either directly or by contract with a separate entity.

(j) Any plan offering a discount program must maintain a toll-free telephone number (or require that an independent contracting entity maintain a toll-free telephone number) for discount program members to obtain additional information about the program and lists of providers participating in the program. The list of participating providers shall identify the professional credentials of each participating provider and shall provide a description of the specialties represented by those credentials.

(k) Any health plan offering a discount program must ensure that the discount program will issue at least one membership card to each member to serve as proof of membership in the discount program, and at least one set of disclosure materials (including at a minimum all provisions required by subsection 1300.49(f)) to each household in which one or more persons are members.

(l) Any plan offering a discount program must ensure that any enrollment form or other membership agreement used for the discount program shall clearly and conspicuously disclose the duration of membership and the amount of the payments that the consumer is obligated to make. The plan must also ensure that all enrollment forms or other membership agreements and disclosure materials shall be in the same language as principally used in any oral sales presentation or negotiation.

(m) Any plan offering a discount program by contract with a separate entity shall require that the separate entity maintain a surety bond in an amount of not less than $50,000.

(n) Any plan offering a discount program by contract with a separate entity shall require that the separate entity shall maintain an agent for service of process in the State of California, and the plan shall provide the name and address of the discount program's agent for service of process upon request of any member of the public. The name and address of the discount program's agent for service of process shall be specified in the notice of material modification submitted to the Department of Managed Health Care to obtain authorization for the discount program.

(o) Any plan offering a discount program shall allow anyone enrolled in the discount program to rescind his or her membership in the discount program within 30 calendar days of becoming a member, without needing to provide any reason, and the plan will refund all enrollment fees paid by that consumer. However, neither money paid, nor bills incurred, by the consumer under the discount program, in return for health care services or products received, are subject to rescission under this subsection.

(p) No plan may offer any health care service through a discount program that is either:

(1) required by the Knox-Keene Act or regulations promulgated pursuant to the Knox-Keene Act; or

(2) already offered as a covered benefit within the Evidence of Coverage (EOC) for the plan contract then in effect for an enrollee who is also a member of the discount program.

(q) No plan shall refer, or permit any contracting provider to refer, a plan enrollee to any discount program except a discount program offered by that plan, in accordance with these regulations.

(r) No health care service plan shall contract with any entity that accepts, collects, or holds money or other compensation from enrollees for services performed or to be performed by a provider contracting to provide services on a discounted basis pursuant to the provisions of this section.

(s) No health care service plan shall contract with any entity that is affiliated with or has any ownership interest in any provider providing services on a discounted basis pursuant to the provisions of this chapter.

(t) The Department shall conduct periodic audits and reviews to determine plan compliance with regulatory requirements pertaining to discount programs. The audits will include, but will not be limited to, an examination and review sufficient to determine whether the promised discounts are, in fact, being provided to members of the discount program. Each plan offering a discount program shall be subject to an audit of its discount program at least once every three calendar years, and more frequently if, in the sole determination of the Department, greater frequency is required to protect California consumers. Reviews of discount programs shall be conducted at the discretion of the Department. All plans offering discount programs are required to cooperate with the Department in the conduct of these audits and reviews, and to provide, within five business days, all documents and other items requested by the Department.

(u) The Department retains the authority to suspend or revoke the license of any plan that offers a discount program not in compliance with laws and regulations. In addition, the Department may assess civil and administrative penalties, and impose injunctive relief, as authorized by laws and regulations. The Department's authority includes, but is not limited to, the assessment of administrative penalties, civil penalties and injunctive relief for conduct that constitutes fraud or unfair competition as defined under Business and Professions Code Section 17200 and 17500. The remedies provided by this section and by other sections of this regulation are not exclusive, and may be sought and employed in any combination to enforce these regulations.

(v) No plan, or affiliated but separate discount program, offering a discount program in compliance with these regulations shall be deemed to be in violation of any provision of Knox-Keene, or of Section 1300.46 of Title 10 of the California Code of Regulations, solely on the basis of offering a discount program. However, the use of bonuses or gratuities in solicitations is still prohibited.

(w) Any member of a discount program may file a grievance in accordance with the plan's grievance procedure, which must comply with all requirements of the Knox-Keene Act and regulations promulgated pursuant to that Act. However, since the plan is required to disclose in writing to each member that the plan does not guarantee the quality of the services or products offered by individual providers beyond confirming the existence and good standing of the professional credentials of the provider, a grievance about quality of care is not required to be processed under the plan's grievance procedure, so long as the plan provides the complainant the name, address, and phone number of the appropriate licensing authority for the provider concerned. A grievance stating that a provider did not provide a service or product offered by the discount program will not be considered a grievance over quality of care, and must be processed in accordance with the plan's grievance procedure. The plan must maintain records of all grievances and complaints filed about the discount program, including those about quality of care, and must include in the records a statement of facts regarding each grievance or complaint; how the grievance or complaint was processed; to which licensing agency a complainant was referred if the grievance or complaint concerned quality of care; the resolution of the grievance or complaint; and all other material information about the grievance or complaint. The plan must maintain records of grievances and complaints under the discount program separately from grievances and complaints regarding the plan's coverage of general health care services included within the Evidence of Coverage for contracts not involving the discount program.

Note: Authority cited: Health and Safety Code Section 1344; References: Health and Safety Code Sections 1345(f), 1346, 1349, 1386, 1387; Business and Professions Code Section 17200; California Code of Regulations, Title 10, Section 1300.46.